

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045598

STATE FILE NUMBER

11980

FILED DEC 22 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

300
1-57

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4170 Lafayette</u>		Length of stay in lb _____	d. STREET ADDRESS (If outside, give location) <u>4170 Lafayette</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna L Dulin</u>			4. DATE OF DEATH Month Day Year <u>Dec 12, 1958</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Richland Center Wis. 1</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Unknown McCarthy</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Cosgrove</u>		14. NAME OF HUSBAND OR WIFE <u>John J. Dulin</u>	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Kathleen Schroeder 4170 Lafayette</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> MINUTES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>	<u>420.0</u>	
	DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____	STATE _____
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21. I attended the deceased from <u>July 2</u> to <u>DEC. 12 '58</u> and last saw her <u>4:45 A</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
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22a. SIGNATURE <u>R. M. Schmitt</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>3701 Grandel Square</u>	22c. DATE SIGNED <u>12/12/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Dec 12, 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive</u>	23d. LOCATION (City, town, or county) (State) <u>Janesville Wisconsin</u>
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24. FUNERAL DIRECTOR <u>E. J. Schnur</u> ADDRESS <u>3125 Lafayette</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 12 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Thomas R Fenwick*

Licensed Embalmer No. *3793*
P. O. Address *3125 Fayette*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.